		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033779

Facility Name: Covenant Health Care Center-Northbrook

Address: 2155 Pfingsten Road (Number) Northbrook (City) 60062 (Zip Code)

County: Cook

Telephone Number: (847) 480-6380 **Fax #** (847) 480-7666

IDPA ID Number: 52-1115873001

Date of Initial License for Current Owners: 01/20/72

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(C)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Barry C. Scutillo, CPA **Telephone Number:** (954) 721-5222

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/00 to 01/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Richard W. Olson
(Title) Vice President, Finance

Paid Preparer
(Signed) See Attached Accountants Report (Date)
(Print Name and Title) Scutillo Blake McMillan & Joyce, PA
(Firm Name & Address) 8000 North University Drive, Fort Lauderdale, Florida 33321
(Telephone) (954) 721-5222 Fax # (954) 722-6692

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,332	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	64	Sheltered Care (SC)	64	23,424	5
6		ICF/DD 16 or Less			6
7	166	TOTALS	166	60,756	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,961	28,910	1,407	35,278	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		20,463		20,463	12
13	DD 16 OR LESS					13
14	TOTALS	4,961	49,373	1,407	55,741	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.75%

D. How many bed-hold days during this year were paid by Public Aid?
35 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/20/72

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,407

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 01/31/01 Fiscal Year: 01/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	431,009	54,873	(9,704)	476,178		476,178		476,178			1
2	Food Purchase		376,054		376,054		376,054		376,054			2
3	Housekeeping	171,403	24,255	3,895	199,553		199,553		199,553			3
4	Laundry	25,831	19,488	99,398	144,717		144,717	(52,796)	91,921			4
5	Heat and Other Utilities			216,708	216,708		216,708		216,708			5
6	Maintenance	71,370	20,472	130,218	222,060		222,060	(11,340)	210,720			6
7	Other (specify):*											7
8	**TOTAL General Services**	699,613	495,142	440,515	1,635,270		1,635,270	(64,136)	1,571,134			8
	B. Health Care and Programs											
9	Medical Director			23,881	23,881		23,881		23,881			9
10	Nursing and Medical Records	2,327,545	82,423	6,118	2,416,086		2,416,086		2,416,086			10
10a	Therapy	81,392	439	26,270	108,101		108,101		108,101			10a
11	Activities	153,812	4,322	54,130	212,264		212,264	(19,309)	192,955			11
12	Social Services	93,903	405	752	95,060		95,060		95,060			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,656,652	87,589	111,151	2,855,392		2,855,392	(19,309)	2,836,083			16
	C. General Administration											
17	Administrative	94,974		343,824	438,798	(14,170)	424,628	114,299	538,927			17
18	Directors Fees											18
19	Professional Services			59,446	59,446		59,446		59,446			19
20	Dues, Fees, Subscriptions & Promotions			20,660	20,660		20,660	(5,214)	15,446			20
21	Clerical & General Office Expenses	242,727	22,946	44,888	310,561		310,561	(794)	309,767			21
22	Employee Benefits & Payroll Taxes			619,693	619,693	14,170	633,863		633,863			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,361	12,361		12,361	(7,196)	5,165			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			18,372	18,372		18,372	(147)	18,225			26
27	Other (specify):*											27
28	**TOTAL General Administration**	337,701	22,946	1,119,244	1,479,891		1,479,891	100,948	1,580,839			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,693,966	605,677	1,670,910	5,970,553		5,970,553	17,503	5,988,056			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Covenant Health Care Center-Northbrook #0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			571,101	571,101		571,101	(235,131)	335,970			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			356,593	356,593		356,593	(356,593)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			1,160	1,160		1,160		1,160			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			928,854	928,854		928,854	(591,724)	337,130			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		347,988	24,192	372,180		372,180		372,180			39
40	Barber and Beauty Shops	33,250		881	34,131		34,131		34,131			40
41	Coffee and Gift Shops		(30)		(30)		(30)		(30)			41
42	Provider Participation Fee							42,075	42,075			42
43	Other (specify):*			44,995	44,995		44,995	(44,995)				43
44	**TOTAL Special Cost Centers**	33,250	347,958	70,068	451,276		451,276	(2,920)	448,356			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,727,216	953,635	2,669,832	7,350,683		7,350,683	(577,141)	6,773,542			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(235,131)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(366,195)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,140)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(131,049)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (733,515)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	114,299	17	34
35	Other- Attach Schedule **Provider Part. Fee**	42,075	42	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 156,374		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (577,141)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Covenant Health Care Center-Northbrook

ID# 0033779

Report Period Beginning: 02/01/00

Ending: 01/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non allowable dues & subscriptions	$ (4,074)	20	1
2				2
3	Non allowable conference & seminar exp	(2,589)	24	3
4	Non allowable travel & auto exp	(4,607)	24	4
5	Emp Recognition, Marketing Costs	(40,021)	43	5
6	Flowers, Cable TV access	(19,309)	11	6
7	Contributions	(120)	21	7
8	Rental Property Expense	(4,974)	43	8
9				9
10	Non allowable Vehicle Expense	(1,631)	6	10
11	Non allowable Vehicle Expense	(128)	26	11
12	Offset Transportation Revenue	(3,262)	6	12
13	Offset Transportation Revenue	(19)	26	13
14				14
15	Record Amort of Loss On Early Ext. of Debt	9,602	32	15
16				16
17	Remove Paint Exp deferred	(17,054)	6	17
18	Record deferred maint exp for current fiscal year	10,607	6	18
19	Vending Revenue	(97)	21	19
20	Telephone Revenue	(577)	21	20
21	Laundry Revenue	(52,796)	4	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(131,049)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 **Report Period Beginning:** 02/01/00 **Ending:** 01/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(52,796)	0	0	0	0	0	0	0	0	0	0	(52,796)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(11,340)	0	0	0	0	0	0	0	0	0	0	(11,340)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(64,136)	0	0	0	0	0	0	0	0	0	0	(64,136)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(19,309)	0	0	0	0	0	0	0	0	0	0	(19,309)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(19,309)	0	0	0	0	0	0	0	0	0	0	(19,309)	16
	C. General Administration													
17	Administrative		114,299	0	0	0	0	0	0	0	0	0	114,299	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,214)	0	0	0	0	0	0	0	0	0	0	(5,214)	20
21	Clerical & General Office Expenses	(794)	0	0	0	0	0	0	0	0	0	0	(794)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7,196)	0	0	0	0	0	0	0	0	0	0	(7,196)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(147)	0	0	0	0	0	0	0	0	0	0	(147)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13,351)	114,299	0	0	0	0	0	0	0	0	0	100,948	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(96,796)	114,299	0	0	0	0	0	0	0	0	0	17,503	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 **Report Period Beginning:** 02/01/00 **Ending:** 01/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(235,131)	0	0	0	0	0	0	0	0	0	0	(235,131)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(356,593)	0	0	0	0	0	0	0	0	0	0	(356,593)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(591,724)	0	0	0	0	0	0	0	0	0	0	(591,724)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	42,075	0	0	0	0	0	0	0	0	0	0	42,075	42
43	Other (specify):*	(44,995)	0	0	0	0	0	0	0	0	0	0	(44,995)	43
44	**TOTAL Special Cost Centers**	(2,920)	0	0	0	0	0	0	0	0	0	0	(2,920)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(691,440)	114,299	0	0	0	0	0	0	0	0	0	(577,141)	45

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Retirement Comm., Inc.	100.00	See Attached List	Various	Cov. Retire. Comm.	Chicago	Mgt Services

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 343,824	Covenant Retirement Communities, Inc.	100.00%	$ 458,123	$ 114,299	1
2	V	19	Professional Services	59,446	Covenant Retirement Communities, Inc.			(59,446)	2
3	V		Detail:			100.00%			3
4	V	19	Audit Services				10,335	10,335	4
5	V	19	Data Processing				17,688	17,688	5
6	V	19	Cost Report Preparation]				5,496	5,496	6
7	V	19	Payroll Processing				9,656	9,656	7
8	V	19	Legal Services				626	626	8
9	V	19	Therapy Consulting				11,375	11,375	9
10	V	19	Health Ins Consulting				4,270	4,270	10
11	V	22	Pension Expense	34,556			34,556		11
12	V								12
13	V								13
14	Total			$ 437,826			$ 552,125	$ * 114,299	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Covenant Retirement Communities, Inc.
Street Address: 5115 North Francisco Avenue, Suite 200
City / State / Zip Code: Chicago, Illinois 60625
Phone Number: (773) 878-2294
Fax Number: (773) 878-2289

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management Fees	Actual Net Svc Rev	94,229,000	32	$ 4,976,952	$ 1,813,264	6,509,645	$ 343,824	1
2	19	Audit Services	Fixed Fee Per Mo. (1)	32	32	251,837	0	1	10,335	2
3	19	Data Processing	Fixed Fee Per Mo. (2)	32	32	476,276	Not Available	1	17,688	3
4	19	Cost Report Preparation	Fixed Fee Per Mo. (3)	14	14	66,960	0	1	5,496	4
5	22	Pension Expense	Fixed Fee Per Mo. (4)	32	32	390,796	0	1	34,556	5
6	19	Payroll Processing	Fixed Fee Per Mo. (5)	32	32	9,656	0	1	9,656	6
7	19	Legal Fees	Direct Cost	1	1	626	0	1	626	7
8	19	Therapy Consulting	Direct Cost	1	1	11,375	0	1	11,375	8
9	19	Health Insurance Consulting	Direct Cost	1	1	4,270	0	1	4,270	9
10										10
11										11
12										12
13										13
14		NOTE:								14
15		(1) Audit services are based upon a fixed fee of $861/month. The G/L is adjusted at year end to reflect actual expense								15
16		(2) Data processing is based on a fixed fee of $1,474/month.								16
17		(3) Medicare cost report preparation is based on a fixed fee of $458/month.								17
18		(4) Pension plan expense is based on a fixed fee of $2,880/month.								18
19		(5) Payroll processing is based ona fixed fee of $805/month.								19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,188,748	$ 1,813,264		$ 437,826	25

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Senior Secured Notes		X	Refinance of Debt		02/01/93	$ 780,600	$ 236,400	08/01/02	Variable	$ 28,338	1
2	1992 T/E Term Bonds		X	Refinance of Debt		02/01/93	1,898,492	1,221,203	12/01/15	Variable	92,811	2
3	1992 T/E 5 Yr Extend. Bonds		X	Refinance of Debt		02/01/93	2,226,827	2,226,831	12/01/15	Variable	116,909	3
4												4
5	See Attached Schedule		X	Refinance of Debt		01/28/98	1,391,331	1,101,179	01/28/15	Variable	56,944	5
	Working Capital											
6	Interco Notes To/From CRC			Working Capital		02/01/95	(6,217,334)	(4,054,702)	N/A	Variable		6
7	Interco Notes			Working Capital		02/01/95	(2,925,000)	(2,904,000)	N/A	Variable		7
8	Amort of C.O. Financing										61,591	8
9	TOTAL Facility Related						$ (2,845,084)	$ (2,173,089)			$ 356,593	9
	B. Non-Facility Related*											
10												10
11	Interest - See Attached Sch										(366,195)	11
12												12
13	Add: Amort loss on EE of debt			(See Below)							9,602	13
14	TOTAL Non-Facility Related						$	$			$ (356,593)	14
15	TOTALS (line 9+line14)						$ (2,845,084)	$ (2,173,089)			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant Health Care Center-Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033779

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 77,894 B. General Construction Type: Exterior Brick-Masonary Frame Steel Studed Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Covenant Village of Northbrook Residential Independent Living Facility 302,869 sq. ft., 306 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1973	$ 70,272	1
2					2
3	TOTALS			$ 70,272	3

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	166		1974	1974	$ 1,467,406	$ 36,685	40	$ 36,685	$	$ 1,008,842	4
5			1975	1975	2,250	56	40	56		1,490	5
6			1976	1976	1,916	48	40	48		1,254	6
7			1977	1977	2,769	69	40	69		1,696	7
8			1978	1978	7,643	191	40	191		4,490	8
	Improvement Type**										
9	Building Improvements - Brandel Care Center			1979	18,220	455	40	455		10,248	9
10				1980	20,844	521	40	521		11,204	10
11				1981	38,116	953	40	953		19,535	11
12				1982	3,360	84	40	84		1,638	12
13				1984	13,999	350	40	350		6,125	13
14				1985	162,076	4,052	40	4,052		66,734	14
15				1986	36,791	978	40	978		14,107	15
16				1987	17,303	433	40	433		6,272	16
17				1988	30,032	751	40	751		10,136	17
18				1989	472,871	11,822	40	11,822		147,772	18
19				1989	115,230	2,881	40	2,881		33,129	19
20				1990	77,922	1,948	40	1,948		20,454	20
21				1991	25,051	626	40	626		5,949	21
22				1992	7,901	198	40	198		1,680	22
23				1994	19,938	498	40	498		3,738	23
24	52 pair of shear and rods - all patient rooms			1997	8,000	200	40	200		1,000	24
25	14 cubicle curtains - wings 100 and 200			1997	2,636	66	40	66		330	25
26	A/C equipment			1998	3,549	89	40	89		311	26
27	Room remodeling			1999	2,989	75	40	75		187	27
28	Window treatments			1999	29,864	747	40	747		1,867	28
29	Heating A/C work			1999	1,665	42	40	42		105	29
30	New light fixtures			1999	1,647	41	40	41		104	30
31	Hall door replacement			1999	329	8	40	8		20	31
32	Roof repair/replacement			1999	133,950	3,349	40	3,349		8,372	32
33	New bathrooms			1999	9,685	242	40	242		605	33
34	Renovation/modernization			2000	4,013,267	100,332	40	100,332		150,497	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Alarm Units	2000	$ 2,204	$ 27	40	$ 27	$	$ 27	37
38	Drapes	2000	69	1	40	1		1	38
39	Doors	2000	1,254	15	40	15		15	39
40	Finish Resident Rooms	2000	26,608	332	40	332		332	40
41	Remodel Bath	2000	3,100	39	40	39		39	41
42	Roof Repair	2000	400	5	40	5		5	42
43	Painting	2000	780	10	40	10		10	43
44	Renovation/Modernization	2000	169,917	2,124	40	2,124		2,124	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,953,551	$ 171,343		$ 171,343	$	$ 1,542,444	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,953,551	$ 171,343		$ 171,343	$	$ 1,542,444	1
2	Building Improvements - Axelson Manor	1987	9,537	238	40	238		3,457	2
3		1988	11,898	297	40	297		4,015	3
4		1989	25,256	631	40	631		7,892	4
5		1990	6,612	165	40	165		1,901	5
6		1991	5,581	140	40	140		1,466	6
7		1992	10,312	258	40	258		2,449	7
8		1993	10,084	252	40	252		2,143	8
9		1994	11,446	286	40	286		2,146	9
10		1995	4,965	124	40	124		807	10
11	Padding and Carpeting	1996	3,410	85	40	85		469	11
12	Drapes and Shears	1996	1,857	46	40	46		254	12
13	Carpet	1997	11,718	293	40	293		1,318	13
14	Food Service Renovations	1997	5,951	149	40	149		670	14
15	New Building	1998	2,060,269	51,508	40	51,508		180,275	15
16	New Carpet	1998	6,817	170	40	170		425	16
17	Drapes/Shears for Rooms	1998	554	14	40	14		35	17
18	New Roof	1998	38,000	950	40	950		2,376	18
19	Additional Construction	1998	72,323	1,809	40	1,809		4,523	19
20	Floor Covering	2000	3,308	41	40	41		41	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,253,449	$ 228,799		$ 228,799	$	$ 1,759,106	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,253,449	$ 228,799		$ 228,799	$	$ 1,759,106	1
2	Land Improvements								2
3		1981	925	23	20	23		925	3
4		1982	14,374	719	20	719		14,018	4
5		1985	27,727	1,386	20	1,386		23,257	5
6		1989	1,500	75	20	75		937	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,297,975	$ 231,002		$ 231,002	$	$ 1,798,243	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,036,160	$ 335,821	$ 101,626	$ (234,195)	10	$ 390,601	71
72	Current Year Purchases	38,775	1,939	1,939		10	1,939	72
73	Fully Depreciated Assets	393,896				10	393,896	73
74								74
75	TOTALS	$ 1,468,831	$ 337,760	$ 103,565	$ (234,195)		$ 786,436	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Res. Trans., Maint.	Bus-1987	1987	$ 32,205	$	$	$	4	$ 32,205	76
77	Resident Transportation	2 Busses-1993	1993	68,425				5	68,425	77
78	Maintenance	Truck	1993	22,456				5	22,456	78
79	Resident Transportation	Bus-2000	2000	14,034	2,339	1,403	(936)	5	1,403	79
80	TOTALS			$ 137,120	$ 2,339	$ 1,403	$ (936)		$ 124,489	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,974,198	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 571,101	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 335,970	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (235,131)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,709,168	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-care Vehicles	$ 24,339	$	$ 24,339	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 24,339	$	$ 24,339	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [ ] YES [X] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$	242	$ 9,699	$	242	$ 9,699	1
2	Licensed Speech and Language Development Therapist	10a	hrs		67	2,793		67	2,793	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		26	1,103		26	1,103	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts		11,924		341,748	11,924	341,748	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-Ray/Lab	39			140		1,416	140	1,416	13
14	TOTAL			$	12,399	$ 13,595	$ 343,164	12,399	$ 356,759	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 01/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 165,879	$ 17,226,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	397,596	9,864,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		11,414,000	5
6	Prepaid Insurance		1,157,000	6
7	Other Prepaid Expenses	(439)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 563,036	$ 39,661,000	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,186,750	93,058,000	12
13	Land	501,693	17,382,000	13
14	Buildings, at Historical Cost	10,989,697	319,433,000	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,343,145	41,970,000	16
17	Accumulated Depreciation (book methods)	(4,019,494)	(129,643,000)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		39,505,000	21
22	Other Long-Term Assets (specify):	2,092,359	19,824,000	22
23	Other(specify): Construction In Progress		46,224,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 12,094,150	$ 447,753,000	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,657,186	$ 487,414,000	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 163,392	$ 11,829,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		8,139,000	28
29	Short-Term Notes Payable		3,685,000	29
30	Accrued Salaries Payable	351,544	5,053,000	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,382		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	55,534	1,621,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	16,178	5,427,000	36
37	Current Maturities-Long Term Debt	212,714	5,900,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 808,744	$ 41,654,000	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,572,899	197,962,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interco. Accts, Other Liabilities	(6,877,770)	8,529,000	43
44	Deferred Revenue		171,338,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (2,304,871)	$ 377,829,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (1,496,127)	$ 419,483,000	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 14,153,313	$ 67,931,000	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,657,186	$ 487,414,000	48

***(See instructions.)**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,995,668	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,995,668	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,157,646	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,157,645	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 14,153,313	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,472,258	1
2	Discounts and Allowances for all Levels	(747,954)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,724,304	3
	B. Ancillary Revenue		
4	Day Care	168,599	4
5	Other Care for Outpatients		5
6	Therapy	432,916	6
7	Oxygen	12,440	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 613,955	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	58,592	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	389,401	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,346	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	52,796	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 510,135	23
	D. Non-Operating Revenue		
24	Contributions	97,622	24
25	Interest and Other Investment Income***	525,439	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 623,061	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Other Non Operating Revenue**	36,872	28
28a	**Rounding**	2	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 36,874	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,508,329	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,635,270	31
32	Health Care	2,855,392	32
33	General Administration	1,479,891	33
	B. Capital Expense		
34	Ownership	928,854	34
	C. Ancillary Expense		
35	Special Cost Centers	451,276	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,350,683	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,157,646	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,157,646	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,748	2,000	$ 63,914	$ 31.96	1
2	Assistant Director of Nursing	2,337	2,747	60,182	21.91	2
3	Registered Nurses	33,445	35,952	826,946	23.00	3
4	Licensed Practical Nurses	1,819	2,021	35,848	17.74	4
5	Nurse Aides & Orderlies	94,024	105,450	1,293,646	12.27	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,288	3,607	81,392	22.57	7
8	Rehab/Therapy Aides					8
9	Activity Director	826	891	15,379	17.26	9
10	Activity Assistants	10,419	11,400	135,023	11.84	10
11	Social Service Workers	5,178	5,573	93,903	16.85	11
12	Dietician					12
13	Food Service Supervisor	5,077	6,203	118,145	19.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,739	33,840	312,864	9.25	15
16	Dishwashers					16
17	Maintenance Workers	4,060	4,514	71,370	15.81	17
18	Housekeepers	15,606	17,705	171,403	9.68	18
19	Laundry	2,122	2,356	25,831	10.96	19
20	Administrator	2,352	2,656	94,974	35.76	20
21	Assistant Administrator					21
22	Other Administrative	2,145	2,451	34,370	14.02	22
23	Office Manager					23
24	Clerical	14,950	16,144	208,357	12.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,727	1,885	34,331	18.21	31
32	Other Health Care(specify)					32
33	Other(specify)	3,337	3,996	49,338	12.35	33
34	TOTAL (lines 1 - 33)	235,199	261,391	$ 3,727,216 *	$ 14.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	35	$ 5,075	1, 3	35
36	Medical Director	Monthly	23,881	9, 3	36
37	Medical Records Consultant	32	166	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	166	1,761	10, 3	39
40	Physical Therapy Consultant	Monthly	17,094	10a, 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	110	3,066	11, 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	343	$ 51,043		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides	N/A			52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Mueller	Administrator	0	$ 19,700
Paul D. Peterson	Administrator	0	44,967
Neil Warnygora	Administrator	0	16,137
Employee Benefits			14,170
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,974

B. Administrative - Other

Description	Amount
Covenant Retirement Communities, Inc.	$
Management Services	343,824
TOTAL (agree to Schedule V, line 17, col. 3)	$ 343,824
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Deloitte & Touche, CPA	Audit Services	$ 10,335
ADP	Payroll Services	9,656
Covenant Retirement Comm.	Data Processing	17,688
Covenant Retirement Comm.	Legal Services	626
Seabury and Smith	Health Ins Mgt Consultant	4,270
Scutillo Blake McMillan & Joyce	Cost Report Preparation	5,496
Health Resources	Therapy Consulting	11,375
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 59,446

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,996
Unemployment Compensation Insurance	131
FICA Taxes	258,967
Employee Health Insurance	274,149
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	8,091
Pension Plan	34,556
Other	803
Reclass of Administrator Emp Benefits	14,170
TOTAL (agree to Schedule V, line 22, col.8)	$ 633,863

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,424
Health Care Worker Background Check	
(Indicate # of checks performed)	
Promotion/Public Relations	1,140
Dues and Subscriptions	14,096
Unallowable Dues & Subscriptions	(4,074)
Less: Public Relations Expense	( )
Non-allowable advertising	(1,140)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,446

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,767
Non Allowable Out of State Travel	(1,767)
In-State Travel	4,551
Non Allowable In State Travel	(2,840)
Seminar Expense	6,043
Non Allowable Seminar Expense	(2,589)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,165

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/00 Ending: 01/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Interior Painting	03/97	$ 408	3	$ 125	$ 136	$ 136	$ 11	$	$	$	$	$
2	Interior Painting	06/97	805	3	179	268	298	90					
3	Interior Painting	07/97	860	3	167	287	287	119					
4	Interior Painting	08/97	1,604	3	267	535	535	267					
5	Interior Painting	09/97	1,110	3	154	370	370	216					
6	Interior Painting	10/97	805	3	90	268	268	179					
7	Interior Painting	11/97	815	3	68	272	272	203					
8	Interior Painting	12/97	610	3	34	203	203	170					
9	Interior Painting	01/98	585	3	16	195	195	179					
10	Heating Unit Repair	03/97	2,212	3	676	737	737	62					
11	Interior Repainting	12/98	6,174	3		172	2,058	2,058	1,886				
12	See Schedule	FY2000	14,525	3			1,917	4,842	4,842	2,924			
13	See Schedule	FY2001	17,054	3				2,211	5,686	5,686	3,471		
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 47,567		$ 1,776	$ 3,443	$ 7,276	$ 10,607	$ 12,414	$ 8,610	$ 3,471	$	$

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 **Report Period Beginning:** 02/01/00 **Ending:** 01/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LNA $7,837**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,386** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **42,075**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **30,814**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Deloitte & Touche LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.